

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155269		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2011	
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN46514			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/21/11</p> <p>Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, East Lake Nursing and Rehabilitation Center was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies</p>			K0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Life Safety Desk Review for Paper Compliance, effective on or after June 30, 2011.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. This facility was built in 1984. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 160 and had a census of 118 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/24/11.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0018 SS=B	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 17 corridor doors on the 200 wing was free from impediments to closing. This deficient practice affects residents in the facility's 200 wing including staff and visitors.</p> <p>Findings Include:</p> <p>Based on observation made at 1:20 p.m. on 06/21/11 with the maintenance supervisor and facility administrator, the corridor door to resident room 212 was blocked open by a door wedge. The maintenance supervisor and</p>		K0018	<p>K 018</p> <p>It is the practice of this provider to ensure that doors protecting corridor openings have no impediment to the closing of the doors.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The door wedge was immediately removed from the corridor door of room 212. Staff was retrained on the importance of keeping the door unblocked. The visiting family member was also instructed on the policy. <i>See Addendum A (staff</i></p>		07/01/2011	

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	administrator stated at the time of observation, they were not aware of the problem. 3.1-19(b)				<i>in-service records)</i> How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be effected by this practice. Corridor doors were re-checked to ensure that they were not improperly blocked. No others were found to have any blockage. The resident in room 212 was educated about the policy and facility staff was retrained on the resident corridor policy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Areas will be observed during daily routine rounds by housekeeping, maintenance and management staff for any obstructed corridor doors. Any areas of concern will immediately resolved. The Administrator, Social Services and Activities will also educate residents and family members about the need to not put wedges and such (knick knacks, etc.) in front of resident doors.		

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K0144 SS=C	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load for the monthly load test for the generator ran for at least 30 minutes at 30% of the nameplate rating for 12 of 12</p>		K0144	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Areas will be observed during daily routine rounds by housekeeping, maintenance and management staff for any obstructed corridor doors. Any areas of concern will immediately resolved.</p> <p>The maintenance director will also provide a report to the facility Safety and Q.A. & A. Committees at their monthly meetings for any additional action or follow up.</p> <p>Compliance Date: July 1, 2011</p> <p>K 144 The facility has a Generator that provides emergency power. The generator is inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.</p>		07/01/2011	

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	<p>months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of monthly load</p>				<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The facility had its contracted Generator Service Provider to do a new inspection and 30 minute load test on June 23, 2011 to ensure the generator was fully operational and could sustain the required load in accordance with NFPA 99. The Administrator also retrained the Maintenance Director on the 30-minute load test requirements including documenting the percentage of load capacity. A new tracking form was also created and is now being used by facility. <i>See enclosed items: Addendum B (inspection report), Addendum C (retraining) and Addendum D (new tracking form).</i></p> <p>How will you identify other residents having the potential to be</p>		

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	<p>test record documentation with the maintenance supervisor and facility administrator at 12:50 p.m. on 06/21/11, monthly logs for the period of July 2010 through June 2011 show the emergency generator ran for only 20 minutes each month for the 12 month period and the percentage of load capacity for the last year was not documented. Based on interview at the time of record review, the maintenance supervisor stated he was not aware of the requirements and was working on a revised data collection sheet.</p> <p>3.1-19(b)</p>				<p>affected by the same deficient practice and what corrective action will be taken</p> <p>All residents have the potential to be effected by this practice. Correction of the facility's existing generator test procedures will resolve the concern and provide ongoing compliance.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>The facility will continue to conduct generator load tests for at least 30 minutes, document accordingly and also have outside contractor do load test as part of their routine inspections and service. Documentation shall include load tests and percentage of load capacity.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The facility's Executive Director and Maintenance Director will regularly review Generator</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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					Reports and Logs. Any concerns will be promptly addressed. The maintenance director will also provide a report to the facility Safety and Q.A. & A. Committees at their monthly meetings for any additional action or follow up. Compliance Date: July 1, 2011.		